

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/23/2012
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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An annual recertification survey and an abbreviated survey (KY #17336, KY #17388, and KY #17335) was conducted on 02/21/12 through 02/23/12 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest S/S of an "E." KY #17335 was substantiated. KY #17336 and KY #17388 were unsubstantiated.	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225		
			F225 483.13 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	4/6/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADM	(X6) DATE 3/18/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268	
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F 225	<p>Continued From page 1 investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy/procedure, it was determined the facility failed to thoroughly investigate an alleged violation and prevent further potential abuse during the investigation for two residents (#6 and #12), in the selected sample of twelve residents. On 08/25/11, Resident #12 alleged he/she had \$1,700.00 that was missing and he/she alleged Certified Nurse Aide (CNA) #2 took the money. A review of the facility's investigation revealed there was no evidence of an interview with Resident #12 or any other residents in the facility. On 09/21/11, Resident #6 alleged Registered Nurse (RN) #3 grabbed his/her arm and threatened to have him/her removed from the facility. A review of the facility's investigation revealed there was no evidence of an interview with Resident #6, his/her family or the alleged perpetrator (RN #3).</p> <p>The findings include: A review of the facility's policy/procedure, "Prevention and Reporting:</p>	F 225	<p>1. Resident #12 no longer resides at the center. On 3/13/2012, resident #6 was interviewed by the Social Services Director to identify any concerns with abuse or neglect by any current staff or resident; none were identified. Resident #6's family was interviewed on 3/14/12 to ensure satisfaction with resident #6's care as well as to identify any concerns with suspected abuse or neglect of any current employee. None were identified. RN #3, CNA #1 and CNA #2 are no longer employed by the facility.</p> <p>2. All current interviewable residents will be interviewed by 4/5/2012 to determine if they have had missing personal items or have had allegations of abuse or neglect. Any allegations will be reported to the appropriate authorities and fully investigated. The interviews will be conducted by the Administrator, Director of Nursing, Assistant Director of Nursing, or Social Services Director. In addition, all current non-interviewable residents will be physically assessed by licensed nursing staff to determine if there are any indications of abuse or neglect including Injury of Unknown Origin. This will be completed by 4/5/2012. Any identified will be reported to the appropriate report agencies and investigated RN #3, CNA #1 and CNA #2 are no longer employed by the facility.</p>	

L P Conroy, ADM 3/18/12

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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 225	<p>Continued From page 2</p> <p>Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property" dated 10/99 and revised 02/11, revealed all allegations that meet the definition of abuse, and substantiated violations, will be reported to State agencies and to all other agencies including the local law enforcement, elder abuse agencies, and Adult Protective Services as required. The facility takes all necessary corrective actions depending on the results of the investigation. The Administrator is responsible for the assurance of this policy/procedure.</p> <p>1. A closed record review revealed Resident #12 was admitted to the facility on 06/13/11 with diagnoses to include Diabetes Mellitus Type II, Hypertension, and Amputation Below the Knee Unilateral. The resident was discharged home on 11/01/11.</p> <p>A review of the facility's investigation revealed, on 08/26/11, Resident #12 told CNA #1 that he/she had \$1,700.00 missing. Resident #12 alleged his/her money came up missing each night CNA #2 worked. On 08/29/11, the facility submitted a final investigation where the allegation was determined to be unsubstantiated related to inconsistent money amounts and lack of dates provided when the money was missing. Further review of the investigation revealed the facility provided no evidence of interviews conducted with the victim (Resident #12) and no evidence of interviews with other residents residing on the same hall to determine if any personal items were missing when CNA #2 was on duty.</p> <p>An attempt to interview Resident #12 was</p>	F 225	<p>3. The Administrator will be re-educated by the Regional Director of Operations on the facility policy and regulatory requirements of completing a thorough investigation to include documentation of interviews and responsibility of the Administrator to assure all investigation are thorough and documentation is present. This re-education will be completed by 3-20-2012. All staff will be re-educated by the District Education and Training Director or the Administrator on the facility policy related to abuse and neglect. This re-education will be completed by 4/5/2012 with no staff working after 4/5/2012 without having received this re-education.</p> <p>4. The Administrator will review all facility investigations for three (3) months to ensure the facility conducted a thorough and complete investigation to include all applicable resident, staff and family interviews, with supportive documentation. Results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>		

LP Company, ADM 3/18/12

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F 225	Continued From page 3 unsuccessful related to the phone number provided was no longer a working number. An interview with CNA #1, on 02/22/12 at 8:59 AM, revealed she provided Resident #12 with a blanket, on 08/25/11, when the resident stated he/she was tired of CNA #2 "using him/her for money." CNA #1 was told by Resident #12 that CNA #2 took \$1,700.00 from him/her. CNA #1 then reported the allegation to the Assistant Director of Nursing (ADON) and wrote a statement related to what Resident #12 reported to her. She stated the administrative staff did not speak with her about the resident's complaint or about the CNA who allegedly took the resident's money. An attempt to contact CNA #2, on 02/22/12 at 9:48 AM, on 02/23/12 at 8:57 AM, and on 02/23/12 at 10:44 AM, was unsuccessful. An interview with the former Social Services Director (SSD), on 02/22/12 at 4:03 PM, revealed she, the Administrator and the Activities Director conducted the investigations within the facility. She stated all allegations of abuse were investigated. There was no protocol for completing the investigations and was instructed the investigations were conducted on a case by case basis depending on the nature of the incident. The allegations of abuse were started as soon as administration became aware of the incident. The facility did not provide her with training on how to complete investigations. She stated she was told to talk to the residents and talk with the staff involved in the incident. She investigated Resident #12's complaint about missing money along with the Administrator.	F 225			

LPC Company, ADM 3/18/12

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F 225	<p>Continued From page 4</p> <p>Interviews were conducted with other coherent residents on the hall and witness sheets were completed with the information given to the Administrator. The other residents that were interviewed did not indicate they had any money or personal property missing. The investigation ruled out the CNA did not take the money.</p> <p>An interview with the former Assistant Director of Nursing (ADON), on 02/23/12 at 3:15 PM, revealed he was unable to recall the incident.</p> <p>An interview with the former Director of Nursing (DON), on 02/23/12 at 10:58 AM, revealed she did not complete the investigation related to Resident #12's money. She stated the Administrator informed her she would conduct an investigation.</p> <p>An interview with the Administrator, on 02/22/12 at 1:13 PM, revealed she was trained on how to complete facility investigations. The staff was suppose to immediately notify the physician, responsible party, Administrator, Director of Nursing and Regional compliance officer, regarding an allegation. The nurse was suppose to assess the resident's well-being and initiate an investigation. The nurse also contacted her, who provided direction to the nurse. She initiated an investigation congruently with nursing and she gathered statements from any staff involved with the incident. She interviewed other residents depending on the seriousness of the allegation. CNA #2 was involved in the allegation of misappropriation of property regarding Resident #12. The Administrator assisted the SSD with Resident #12's complaint. There was an interview with CNA #2, a statement was received</p>	F 225			

LPC Company, ADM 3/18/12

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F 225	<p>Continued From page 5</p> <p>from CNA #1 and an interview with the resident's spouse. The allegation was unsubstantiated because the resident kept changing the story about the cash amount, and when Resident #12's spouse was interviewed he/she revealed the resident spent the money, and revealed the money was not taken. She provided no evidence of an interview with Resident #12 or other residents, who resided on the hall, related to missing money or any personal items.</p> <p>2. A record review revealed Resident #6 was admitted to the facility on 11/13/09 with diagnoses to include Diabetes Mellitus, Hypertension, Anxiety, and Seizure Disorder.</p> <p>An interview with Resident #6, on 02/23/12 at 4:35 PM, revealed he/she recalled the incident in September of 2011. Resident #6 revealed someone from the Administrative staff spoke with him/her. The resident demonstrated his/her right arm was held down by RN #3 during the incident, causing him/her pain. The resident revealed he/she reported the incident to his/her family during a visit afterwards.</p> <p>A review of the facility's investigation, dated 09/22/11, revealed the ADON received an allegation from Resident #6, on 09/21/11, regarding the night shift nurse grabbing his/her arm and threatening to have him/her removed from the facility. The ADON reported the incident to the Administrator and the DON, and an investigation was initiated. On 09/26/11, the facility submitted a final investigation and determined RN #3 was in Resident #6's room to provide a G-tube feeding related to a low blood glucose reading. During the investigation, RN #3</p>	F 225			

L Company, Adm 3/18/12

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F 225	<p>Continued From page 6</p> <p>denied pulling the resident's arm and denied making any threatening remarks about having him/her removed from the facility. The facility unsubstantiated the resident's allegation related to no injury to the resident, as well as his/her history of making false accusations. Further review of the facility's investigation revealed the facility provided no evidence of an interview with Resident #6, the resident's family, and no evidence of an interview or written statement by the alleged perpetrator.</p> <p>An interview with RN #3, on 02/23/12 at 9:00 AM, revealed there was an incident with Resident #6, and RN #3 received counseling afterward. The resident alleged that she "hurt" him/her when she completed an Accu check (procedure for monitoring blood glucose). She was not allowed to work on the hall with the resident for two weeks. She was informed the resident had rights and could make his/her own choices. She revealed she was directed to call the Administrator with questions or anytime Resident #6 had a low blood sugar, day or night. The Administrator advised her on what to do when she called about the resident. RN #3 denied any harm to the resident and denied making threats. She did not work with the resident anytime afterward. Additionally, RN #3 did not write a statement regarding the alleged incident.</p> <p>An interview with the former DON, on 02/23/12 at 10:58 AM, revealed the Administrator completed the investigation regarding Resident #6's allegation. On the same day the resident reported the allegation, the resident's family reported that RN #3 held down his/her arm while trying to give him/her a tube feeding. They (Administrator and</p>	F 225			

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F 225	Continued From page 7 DON) spoke with Resident #6's family in an informal session. Following the discussion, she asked the Administrator what she needed to do and was informed by the Administrator that she would conduct the investigation. She was not included in the investigation and RN #3 was off for a couple of days. An interview with the former ADON, on 02/23/12 at 3:15 PM, revealed he did not recall an allegation of abuse made by Resident #6. An interview with the Administrator, on 02/23/12 at 12:03 PM, revealed she conducted the investigation and was assisted in the investigation by the SSD. She directed the SSD in things she needed to do related to the allegation, and the former ADON was conducting interviews. She received statements from anyone involved in the incident, to include staff and residents. She received statements from other staff that may have worked with RN #3 or any residents who were provided care by the RN. The Administrator revealed she suspended RN #3 while the investigation was being completed. While RN #3 was still in her probationary period of employment, she did not have to follow steps regarding write-ups and terminated her. The Administrator provided no evidence she completed an interview with the victim or the alleged perpetrator.	F 225			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of	F 246	483.15 REASONABLE ACCOMODATION OF NEEDS/PREFERENCES	4/6/2012	

A P Conroy, ADM 3/12/12

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F 246	<p>Continued From page 8 the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to follow physician's orders for one resident (#15), not in the selected sample. An observation of the meal service, on 02/21/12, revealed Resident #15 had raw vegetables on his/her plate, and a review of the dietary card revealed these foods were contraindicated.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Physician's Orders," dated July 2008, did not indicate what to do if a physician's order was not followed related to dietary issues.</p> <p>A review of the facility's policy/procedure, "Menu Procedure," dated July 2010, revealed therapeutic diets will be listed at the bottom of the tray identification ticket.</p> <p>A record review revealed Resident #15 was admitted to the facility on 03/11/10 with diagnoses to include Right-sided Weakness, Cardiovascular Accident, Anxiety and Hyperlipidemia.</p> <p>A review of the physician's order, dated 01/27/12, revealed Resident #15 was to have no raw vegetables.</p>	F 246	<p>1. On 2/21/2012, resident #15's physician was notified with no further recommendations made. On 2/21/2012, resident # 15 was fully assessed to ensure there were no signs or symptoms of aspiration or other swallowing issues; no concerns were identified. The Registered Dietician observed on 2/22/2012 that resident # 15 was served the correct diet as ordered by the physician and indicated on the tray card.</p> <p>2. On 2/22/2012 the Registered Dietician observed all current residents who receive a meal tray and noted that all residents were receiving the correct diet as ordered and indicated on the tray card. No concerns were identified.</p> <p>3. All Dietary staff will be re-educated by 4/5/2012 on assuring that the tray cards match what is being served. This education will be completed by the Dietary Service Manager or the Registered Dietitian.</p> <p>4. The Dietary Service Manager or Administrator will audit five (5) meal tray to tray cards five (5) times per week for twelve (12) weeks to assure accuracy of the meal served. Results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review</p>	
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L.P. Company, ADM 3/18/12

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F 246	Continued From page 9 An observation of the lunch meal service, on 02/21/12 at 11:20 AM, revealed the resident had lettuce and tomato on his/her plate. A review of his/her lunch meal tray ticket revealed he/she was not suppose to have raw vegetables. An interview with the Registered Dietician (RD), the Speech Therapist, and the Dietary Manager, on 02/21/12 at 11:30 AM, on 02/21/12 at 3:30 PM, and on 02/22/12 at 9:10 AM, respectively, revealed there was a physician's order in place for this resident indicating "no raw vegetables." The Dietary Manager stated this was an oversight and should not have happened.	F 246	and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary condilions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy/procedure, it was determined the facility failed to ensure food was prepared and distributed and served under sanitary conditions. Observations during initial tour and tray line preparation, on 02/21/12, revealed the kitchen floor had a build-up of dirt and spills, and lower surfaces on carts and counters were dusty with a	F 371	F 371 483.35 FOOD PROCEDURE, STORE/PREPARE/SERVE-SANITARY 1. On 2/22/2012 an observation and test of the sanitation solution revealed that the solution was at the appropriate concentration. This observation was made by the Registered Dietician. On 2/22/2012 the Administrator observed that the carts, counters, and floors were clean and free of grime, spills and build up. On 2/22/2012 the Administrator observed all employees to be wearing hear nets. 2. An observation by the Administrator on 2/24/2012 revealed that the kitchen was clean and sanitary including floors, carts and counters and that all dietary staff present were wearing a hair nets, that test strips for sanitation are present and sanitation levels are witlun appropriate levels. 3. All Dietary Staff will be re-educated by the Dietary Services Manager or Registered Dietitian regarding the cleaning schedule to include floors, counters and carts as well as the requirement to wear hairnets when ever entering the kitchen, the requirement to assure sanitation test strips were present and levels of the sanitation solution are within appropriate levels. This re-education will be	4/6/2012	

L. Conroy, ADM 3/18/12

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 10</p> <p>build-up of grime. Kitchen staff were observed not wearing hair restraints. Observation revealed there were no test strips at the three compartment sink area to test the chemical sanitization bucket.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Cleaning and Sanitizing," revised July 2010, revealed "Fill the third sink with a sanitizing agent at the proper concentration (use test strips). Allow only Nutritional Service employees into the kitchen unless wearing appropriate hair restraints. Follow appropriate procedure for washing and sanitizing kitchen."</p> <p>An observation, during initial tour on 02/21/12 at 9:00 AM, and observation of tray line preparation at 10:40 AM, revealed the kitchen floor to have a build-up of dirt and spills, lower surfaces on the carts and counters were dusty with a build-up of grime. During tray line preparation, an employee entered the kitchen and walked around without a hair restraint. During both initial tour and tray line preparation, there were no test strips available to test the strength of the chemical sanitization bucket; however, staff were observed using the rag in the bucket to wipe off the kitchen surfaces.</p> <p>An observation, on 02/21/12 at 2:00 PM, revealed the Dietary Manager walked into the kitchen without a hair restraint. Further observation revealed the Dietary Manager tested the sanitizing bucket and the result was at an unsafe chemical level of 400 ppm (high range).</p> <p>An interview with the Dietary Manager, on</p>	F 371	<p>completed by 4/5/2012 with no staff working past 4/5/2012 without having received this re-education.</p> <p>4. The Dietary Service Manager or the Administrator will conduct sanitation audits of the kitchen to assure the kitchen is clean and sanitary, that sanitation test strips are available and sanitation levels are within appropriate range and an observation to assure hair nets were being worn. These observations/audits will occur three (3) times per week for four (4) weeks followed by two (2) times per week for eight (8) weeks. Results of these audits will be forwarded to Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>	

LP Company, Admin 3/18/12

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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 11 02/22/12 at 2:00 PM, revealed the staff tested the sanitizing bucket on 02/12/12 at 2:00 PM, and the reading was too high. A safe reading would have been 200 ppm. The Dietary Manager further stated, all dietary staff and anyone who entered the kitchen should wear a hair restraint, and the kitchen floor and all surfaces in the kitchen should be kept clean. An interview with the Regional Nutrition Service Manager, on 02/23/12 at 4:15 PM, revealed anyone who entered the kitchen should wear a hair restraint. There should always be test strips available to test the sanitizing bucket, and the sanitizing solution reading of 400 ppm was too high. The kitchen floor, carts and all kitchen surfaces should always be kept clean.	F 371			
F 514 SS=B	483.75(I)(1) RES RECORDS-COMLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of	F 514	F 514 483.75 RES RECORDS-COMLETE/ACCURATE/ACCESIBLE 1. An observation by the Director of Nurses on 3/5/2012 noted that residents # 1, 2 and 6 had an complete Treatment Administration Record including initial of treatments as completed. 2. An audit of all current residents' Treatment Administration Records for the past fourteen (14) days will be completed by the Assistant Director of Nurses or the Unit Manager by 4/5/2012 to assure that all treatments were initialed as completed or documentation is present as to why a treatment did not occur with physician notification as needed. Any identified concerns will be corrected to include investigation as to why initials were not present and physician notification as needed.	4/6/2012	

JPC Company, ADM 3/18/12

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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 12</p> <p>the facility's policy and procedure, the facility failed to maintain clinical information in the Treatment Administration Record (TAR) for three residents (#1, #2, and #6), in the selected sample of twelve residents.</p> <p>The findings include:</p> <p>A review of the facility's Clinical Programs Manual, 11.1.1 Documentation Program, effective January 2004, revealed "Nursing documentation includes, but is not limited to, the following types of document and records: assessments, meal consumption, and medication/treatment."</p> <p>1. A record review revealed Resident #1 was admitted to the facility on 04/21/11 with diagnoses to include Psychotic Disorder, Mood Disorder, Paraplegia, and Pressure Ulcer to bilateral heels.</p> <p>A review of the treatment administration record (TAR), dated 02/12, revealed that treatments on 02/08/12, 02/11/12, and 02/20/12, from 6:00 PM to 6:00 AM, were not initialed to indicate treatments or safety checks were completed during the shift. The treatments included application of skin prep twice a day to the right hand and the right heel, a fall mat times 1 (x1) to prevent injury, bed against the wall, sensor bed/chair alarm, catheter care, pressure reduction chair cushion, pressure reduction mattress, monitoring of wounds on the left and right heels, and floatation of heels while in the bed.</p> <p>2. A record review revealed Resident #2 was admitted to the facility on 02/28/11 with the diagnoses to include Dementia, Schizophrenia,</p>	F 514	<p>3. All licensed staff will be re-educated on the requirement to assure documentation is complete and accurate by 4/5/2012 with no staff working after 4/5/2012 without having received this re-education. This re-education will be conducted by the District Education and Training Director, Director of Nursing or Assistant Director of Nursing.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will complete a weekly audit for twelve (12) weeks of the Treatment Administration Records to assure that documentation of treatments is complete and meet professional standards. Results of these audits will be forwarded to Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>	

L. Company, ADM 3/18/12

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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 13 Depression and Mild Mental Retardation.</p> <p>A review of the TAR, dated 02/12, revealed that treatments on 02/08/12, 02/09/12 and 02/20/12, from 6:00 PM to 6:00 AM were not initiated to indicate care was provided. The treatments included Secura Extra Protective Cream to the coccyx and groin twice daily, a pressure reduction chair cushion, a pressure reduction mattress, a narrow width wheelchair without a footrest and one fall mat. Further review revealed, on 02/08/12, 02/11/12 and 02/20/12, there was no documentation on the TAR to indicate the skin under Resident #2's splint was monitored on the 2:00 PM to 10:00 PM shift. Additional review revealed the treatment for cleaning the g-tube site with soap and water, and to apply a drain sponge daily was not initiated on 02/11/12, or on 02/17/12 through 02/20/12. Further review of the TAR revealed the sensor bed alarm was not initiated on 02/02/12, 02/04/12, 02/08/12, 02/11/12 and 02/20/12.</p> <p>3. A record review revealed Resident #6 was admitted to the facility on 11/13/09 with diagnoses to include Hypertension, Diabetes, Cerebral Vascular Accident, Seizure Disorder, Anxiety, Depression, Psychosis, Aphasia and Gastroesophageal Reflux Disease.</p> <p>A review of the TAR, dated 02/12, revealed that treatments on 02/08/12, 02/11/12, and 02/20/12, from 6:00 PM to 6:00 AM, were not initiated to indicate treatments or safety checks were completed during the shift. The treatments included Secura extra protective cream, skin integrity check to the right hand splint site, ensuring the head of the bed was raised 45</p>	F 514			

L P Conroy, ADM 3/18/12

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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 14</p> <p>degrees, anti-tipper to the chair was to be in place, high back wheelchair, mat to the floor, air bed with bolsters, trapeze bar placement, and meal documentation in the care tracker.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 02/12/12 at 3:50 PM, revealed there were multiple blanks on the 02/12 TAR from 6:00 PM to 6:00 AM shift. The ADON reviewed Resident #6's record and confirmed there were no initials for 02/08/12, 02/11/12, or 02/20/12. The ADON revealed she could not provide any documented evidence, and there was no explanation provided in the comments section on the TAR or in the nurse's notes.</p> <p>An interview with Registered Nurse (RN) #1, on 02/22/12 at 10:00 AM, revealed if a treatment or medication was missed, she was suppose to document the information in the record and notify the next shift, the Director of Nursing (DON), the family, and the physician.</p> <p>An interview with Licensed Practical Nurse (LPN) #4, on 02/22/12 at 10:44 AM, revealed she worked the 6:00 PM to 6:00 AM shift, on 02/11/12, but arrived late. She stated the nurse that stayed over for her reported that treatments were provided prior to her arrival, so she did not review the TAR. She stated when she was not able to sign off on a completed order, she circled the blank on the TAR, documented information on the back of the record, notified the physician, notified the family, and documented in the nursing notes if needed. She revealed if she noticed a blank on the TAR, she found out who was responsible to see if it was missed or just not signed off.</p>	F 514			

LP Company, Adam 3/18/12

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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 514	Continued From page 15 An interview with LPN #2, on 02/22/12 at 11:07 AM, revealed she does not normally check treatment records during the week because there was a treatment nurse that provided care and completed the TAR checks on both halls during dayshift each week (Monday through Friday). She stated when she found a blank on the TAR, she contacted the responsible person to verify if it was a missed order or just did not sign the TAR. If she was unable to confirm this information, then she notified the supervisor. An interview with the DON, on 02/22/12 at 2:21 PM, revealed that reconciliation of the Medication Administration Record (MAR) or TAR was usually completed by the DON/ADON with assistance from the nightshift nurses. She stated the blanks should have been identified and the staff should be inserviced on how to verify the completion of documentation. She stated there was a breakdown in communication and the staff needed to be inserviced on how to identify any blanks on the MAR/TAR and the steps to ensure complete documentation.	F 514			

LP Company, ADM 3/18/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1968</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator installed in 2004. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 02/23/12. Pembroke Nursing and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty (60) beds and the census was forty seven (47) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>		<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Administrator

(X8) DATE

3/18/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000	K027 NFPA 101 Life Safety Code Standard	4/6/2012
K 027 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of forty seven (47) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/23/12 at 12:30 PM, with the Maintenance Director revealed the cross-corridor doors located next to room #10 would leave a gap of one quarter of an inch or greater when closed preventing the doors from resisting the</p>	K 027	<p>1. The fire barrier door located outside room # 10 will be adjusted to not allow the passage of smoke. This correction will be made by the maintenance director by 4/5/2012.</p> <p>2. The Maintenance Director and Administrator conducted 100% audit by 4/5/2012 to assure all cross-corridor doors close properly to prohibit the passage of smoke. All identified as not closing properly to prohibit the passage of smoke will be adjusted by the Maintenance Director by 4/5/2012.</p> <p>3. The Administrator will re-educate the Maintenance Director on assuring all cross-corridor doors close properly to prohibit the passage of smoke and conducting monthly rounds on cross-corridor doors to assure proper closure. This re-education will be completed by 4/5/2012</p> <p>4. The Maintenance Director will complete an audit of all cross-corridor doors monthly for three (3) months to assure all doors close properly to prohibit the passage of smoke. The results of these audits will be reviewed monthly for three (3) months by the Quality Assurance Committee to assure ongoing compliance and to make further recommendations as needed. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the</p>	

L.P. Company 3/18/12

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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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K 027	Continued From page 2 passage of smoke. Interview, on 02/23/12 at 12:30 PM, with the Maintenance Director revealed they were not aware the doors were not sealing properly. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 101 LIFE SAFETY CODE STANDARD	K 027	Administrator, Director of Nursing, Maintenance Director and the Assistant Director of Nursing, with the Medical Director attending at least quarterly.	
K 050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60)	K 050	K050 NFPA 101 Life Safety Code Standard 1. An un-announced fire drill for third shift will be conducted for the month of march at an un-announced random time and will be conducted by 4/5/2012. 2. An un-announced fire drill for third shift will be conducted for the month of march at an unannounced random time and will be conducted by 4/5/2012. 3. The Administrator will re-educate the Maintenance Director by 4/5/2012 related to assuring that fire drills are conducted monthly on each shift at random times. 4. The Administrator will review the monthly fire drill logs monthly for three (3) months to assure the fire drills are conducted at random times. The results of these reviews will be reviewed monthly for three (3) months by the Quality Assurance Committee	4/6/2012

Lp Company, ADM 3/18/12

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PRINTED: 03/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 050	Continued From page 3 beds and the census was forty seven (47) on the day of the survey. The findings include: Fire Drill review, on 02/23/12 at 12:53 PM, with the Maintenance Director revealed the fire drills, were not being conducted at unexpected times under varied conditions. Third shift fire drills were being conducted at 11:00 PM. This observation was confirmed with the Administrator at the exit conference. Interview, on 02/23/12 at 12:53 PM, with the Maintenance Director revealed he was unaware the fire drills were not being conducted as required.	K 050	to assure ongoing compliance and to make further recommendations as needed. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Maintenance Director and the Assistant Director of Nursing, with the Medical Director attending at least quarterly.		
K 056 SS=E	Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the	K 056	K056 NFPA 101 Life Safety Code Standard 1. The storage area located in the laundry storage room now has at least an eighteen (18) inch clearance as observed by the Administrator on 3/18/2012. New shower curtains have been ordered for the shower rooms on hall 1 and hall 2 that allow an eighteen (18) inch clearance for the sprinkler system and will be installed by 4/5/2012 by TriState Sprinkler Services. Sprinkler heads in room twelve (12) will be replaced to assure both are of the same response as the rest of the compartment. These will be	4/6/2012	

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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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K 056	Continued From page 4 building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of forty seven (47) on the day of the survey.	K 056	replaced by 4/5/2012. 2.The Administrator and Maintenance Director completed a 100% audit on 2/24/12 on all sprinkler heads in the center to determine clearance issues and sprinkler head types in the same compartment. All identified as not having an eighteen (18) inch clearance were immediately corrected by the Administrator and/or the Maintenance Director. Any sprinkler heads identified as not having the same response time as the other sprinkler heads in the compartment will be replaced by 4/5/2012. This replacement will be contracted through Tri-State sprinkler service.	
	The findings include: Observation, on 02/23/12 at 1:27 PM, with the Maintenance Director revealed storage within 48 inches of a sprinkler head located in the Laundry Storage Room. Interview, on 02/23/12 at 1:27 PM, with the Maintenance Director revealed he was not aware the sprinkler head did not have the proper clearance. Observation, on 02/23/12 at 1:42 PM, with the Maintenance Director revealed shower curtains in the Hall 1, and Hall 2 shower room, to only provide 12 inches of mesh at the top of the curtain. The curtains would block the sprinkler from spray development. Observation, on 02/23/12 at 2:26 PM, with the Maintenance Director revealed a standard response sprinkler head and a quick response		3.The Administrator will re-educate the Maintenance Director by 4/5/2012 related to assuring during rounds that the sprinkler heads have an eighteen (18) inch clearance as well as to assure during monthly checks of the sprinkler system that the sprinkler heads are of the same response time. 4. The Maintenance Director or the Administrator will conduct monthly rounds for three (3) months to ensure proper sprinkler clearance and that sprinkler heads are of the same response time for same compartments. The results of these audits will be reviewed monthly for three (3) months by the Quality Assurance Committee to assure ongoing compliance and to make further recommendations as needed. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance	

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K 056	Continued From page 5 sprinkler head in the same compartment located in room #12. Interview, on 02/23/12 at 2:26 PM with the Maintenance Director revealed he was not aware that the sprinklers had to have the same response time if the sprinkler heads are located in the same compartment. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. Reference: NFPA 101 (2000 edition) 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied	K 056	Committee will consist of at a minimum the Administrator, Director of Nursing, Maintenance Director and the Assistant Director of Nursing, with the Medical Director attending at least quarterly.		

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K 056	Continued From page 6 or protected throughout by an approved automatic sprinkler system.	K 056			
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	K072 NFPA 101 Life Safety Code Standard 1. An observation by the Administrator on 3/18/2012 noted that the linen carts were not being stored on hall 1 or hall 2 and the means of egress were clear. 2. The Administrator on 3/18/2012 observed that all hallways and means of egress were free of impediments. 3. All staff will be re-educated by the District Education and Training Director, Administrator, Director of Nursing, Maintenance Director or the Assistant Director of Nursing related to the requirement that all means of egress remain free of impediments. This re-education will be completed by 4/5/2012 with no staff working after 4/5/2012 without having this education. 4. The Maintenance Director or Administrator will conduct daily checks of egress five (5) times per week for two (2) weeks followed by three (3) times per week for ten (10) weeks to assure all means of egress do not have impediments. The results of these audits will be reviewed monthly for three (3) months by the Quality Assurance Committee to assure ongoing compliance and to make further recommendations as needed. If at any time concerns are identified, the Quality Assurance Committee	4/6/2012	
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of forty seven (47) on the day of the survey. The findings include: Observations, on 02/23/12 between 12:30 PM and 2:30 PM, with the Maintenance Director revealed linen carts were being stored in the Hall 1, and Hall 2 corridors. Interview, on 02/23/12 between 12:30 PM and 2:30 PM, with the Maintenance Director revealed the facility routinely stored linen carts in these halls. Reference: NFPA 101 (2000 Edition)				

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K 072	Continued From page 7 Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Maintenance Director and the Assistant Director of Nursing, with the Medical Director attending at least quarterly.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	K130 NFPA 101 Miscellaneous	4/6/2012

	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of forty seven (47) on the day of the survey.		1.The Maintenance Director vacuumed up lint on 2/23/12 and removed the lasp from the laundry storage door as observed by the Administrator on 2/23/2012. The Maintenance Director also removed the slide bolts from closets located in rooms# 12, 21, 22, 25, and 35 on 2/23/12 as observed by the Administrator on 2/23/2012.	
	The findings include: Observation, on 02/23/12 at 1:27 PM, with the Maintenance Director revealed a heavy build up of lint behind the washer and dryer and in the top of the dryer, in the Laundry Room. Interview, on 02/23/12 at 1:27 PM, with the Maintenance Director revealed he was not aware the lint build up was so excessive. Observation, on 02/23/12 at 1:28 PM, with the Maintenance Director revealed an unapproved lock (hasp type) was installed on the egress side of the laundry storage doors. Slide bolt type locks		2.The Maintenance Director and/or the Administrator completed a 100% audit of all means of egress to check for unapproved lasps and slide bolts on 2/23/12. There was another slide bolt located on the closet in room # 17 and that slide bolt was removed as well on 2/23/12 by the Maintenance Director; no other areas of concern were identified. On 2/23/2012 an observation was made by Administrator that there was no lint observed around, on top of or underneath the dryers.	

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K 130	Continued From page 8 were installed on the egress side of closets located in rooms # 12,21,22,25, and 35. Interview, on 02/23/12 at 1:28 PM, with the Maintenance Director revealed he was aware of the lock installed on the door; however, he was not aware that slide bolt locks were prohibited. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	3. All laundry personnel will be re-educated by the housekeeping supervisor related to assuring the areas behind the dryer under and on top of the dryer remain free of lint buildup. This re-education will be completed by 4/5/2012 with no laundry staff working after 4/5/2012 without having received this re-education. The Administrator will re-educate the maintenance Director by 4/5/2012 related to assuring that there are no lasp or slide bolt type locks on the doors leading to a means of egress. 4. The Housekeeping Supervisor will conduct checks of the dryer and dryer area for lint build up five (5) times per week for two (2) weeks followed by three (3) times	
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K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	per week for ten (10) weeks. The Maintenance Director will audit monthly for three (3) months all doors leading to a means of egress to assure that there are not any hasp or slide bolt type locks on. The results of these audits will be reviewed monthly for three months by the Quality Assurance Committee to assure ongoing compliance and to make further recommendations as needed. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Maintenance Director and the Assistant Director of Nursing, with the Medical Director attending at least quarterly.	
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	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of forty seven (47) on the day of the survey. The findings include: Observations, on 02/23/12 between 12:30 PM and 3:00 PM, with the Maintenance Director		K147 NFPA 101 Life Safety Code Standard	4/6/2012
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L P Casper, ADM 3/18/12

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K 147	Continued From page 9 revealed: 1) Storage in front of the electrical panels located in the Therapy Room, and the Maintenance Shop. 2) An unknown wattege vending machine, a 450 watt refrigerator, and a 1200 watt microwave were plugged into a power strip located in the employee lounge. 3) An extension cord was plugged into an outlet in the ceiling of the laundry room and the other end of the cord was hanging over the drain trough for the washing machines. 4) A bed and an oxygen concentrator were plugged into a power strip, also another bed and a mini nebulizer were plugged into another power strip located in room #42. 5) Two (2) beds and an air mattress pump were plugged into a power strip located in room #41. 6) An air mattress, a bed, and a feeding machine were plugged into a power strip located in room #38.	K 147	1. The following areas were corrected by the Maintenance Director: Storage was removed from Therapy Electrical Panel on 2/23/12; storage Removed from Maintenace Electrical Panel on 3/14/12; Powerstrip Removed and applianced rearranged to plug directly into wall recepticale on 2/24/12 in break room; Extension cord removed on 2/23/12 in Laundry Area; Hard wired 20amp outlet additions ordered on 3/5/12 will be installed once received to remove equipment from power strips in room #42 by 4/5/12; Hard wired 20amp outlet additions ordered on 3/5/12 will be installed once received to remove equipment from power strips in room #41 by 4/5/12; Resident and equipment moved and rearranged in order to remove power strip and plug equipment into wall recipticale on 2/27/12 in room #38;	
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	7) A bed and an extension cord were plugged into a power strip located in room #36. 8) Three (3) plugs including the ground fault outlet would not trip the ground fault when tested in the Hopper-Room. 9) Lift battery charger was plugged into a power strip that was plugged into another power strip located in the Hall 2 nurses station. 10) A refrigerator was plugged into a power strip that was plugged into another power strip located in the Business Office. 11) A power strip was plugged into a multi plug adaptor located in the Accounting Office. 12) Lift battery charger was plugged into a power strip located in Hall 1 nurses station. 13) A bed and a air mattress pump were plugged		Extension cord removed on 2/23/12. Hard wired 20amp outlet additions ordered on 3/5/12 will be installed once received to remove equipment from power strips in room #36 by 4/5/12; 1outlet completely removed, other two replaced with working GFI outlets On 3/12/12 in the hopper room; Equipment rearranged and charger plugged directly into wall outlet on 3/1/12, as well as removed pig tailed power strip at Hall 2 Nurses Station;	
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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268
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K 147	<p>Continued From page 10 into a power strip located in room #11. 14) A bed was plugged into a power strip and the wall receptacle looked burnt in room #12. 15) A bed and an air mattress pump were plugged into a power strip located in room #18. 16) A mini nebulizer, a suction pump, a feeding machine, a bed, and a humidifier for the trache were plugged into a power strip located in room #19. 17) A bed and an air mattress were plugged into a power strip located in room #23. 18) A power strip was plugged into another power strip located in the Education and Training Room.</p>	K 147	<p>Equipment rearranged and refrigerator plugged directly into wall outlet on 3/8/12 in the Business Office; Multi plug adapter removed on 2/23/12 in the Accounting Office; Equipment rearranged and charger plugged directly into wall outlet on 3/1/12 at Hall 1 Nurses Station; Hard wired 20amp outlet additions ordered on 3/5/12 will be installed once received to remove equipment from power strips in room #11 by 4/5/12; Outlet replaced and bed plugged into wall outlet on 2/24/12 in room #12; Hard wired 20amp outlet additions ordered on 3/5/12 will be installed once received to remove equipment from power strips in room #18 by 4/5/12; Hard wired 20amp outlet additions ordered on 3/5/12 will be installed once received to remove equipment from power strips in room #19 by 4/5/12; Hard wired 20amp outlet additions ordered on 3/5/12 will be installed once received to remove equipment from power strips in room #23 4/5/12; Equipment rearranged and pig tailed power strip was removed on 3/2/12 in the Education and Training Room.</p>	
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	<p>Interview, on 02/23/12 between 12:30 PM and 3:00 PM, with the Maintenance Director revealed he was not aware the extension cords were only for temporary use, or the power strips were being misused. He was also not aware of the storage in front of the electrical panels, or the ground fault outlet that was not functioning.</p>			
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	<p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid</p>		<p>2. On 2/24/12 The Maintenance Director and Administrator made a 100% audit of facility to check for improper use of power strips and extensions cords, GFI outlets to functioning correctly and the clearance on electrical panels. Concern identified in Room 25 where power strip was in use; hard wired 20amp outlet addition has been ordered....will be replaced by 4/5/2012. 3. The Administrator will reeducate the Maintenance Director by 4/5/2012 on the proper use of power strips, extensions cords,</p>	
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L P Cooper, ADM 3/18/12

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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	Continued From page 11 the need for extension cords or multiple outlet adapters. 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. Reference: NFPA 70 (1999 edition) 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147	GFI outlets and the clearance needed on electrical panels. 4. The Administrator and Maintenance Director will conduct monthly audits of entire facility to ensure that there are no power strips or extension cords in use as well as assuring all electrical panels remain free of obstacles. The Maintenance Director will conduct monthly tests on GFI outlets to ensure they are functioning properly. The results of these audits will be reviewed monthly for three months by the Quality Assurance Committee to assure ongoing compliance and to make further recommendations as needed. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Maintenance Director and the Assistant Director of Nursing, with the Medical Director attending at least quarterly.		

AP Company, am 3/18/12